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ABSTRACT

Conduct disorder (CD), primarily a childhood disorder, is associated with oppositional defiance disorder and antisocial personality disorder. Differentiating between the disorders requires a preview of the intensity of the disorder. There are many approaches to treating CD. The traditional approach has been psychoanalytically oriented psychotherapy, although group therapy is also widely used. The social learning family intervention treatment has received a great deal of support from research. Counseling issues concerning CD which deserve examination are the association with depression and attention deficit hyperactivity disorder. An eclectic approach appears to be the best option for the counselor who is treating the conduct disordered child. Contains 12 references. (Author/RB)

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Counseling the Conduct-Disordered Child

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Abstract

Conduct disorder is primarily a childhood disorder. It is associated with oppositional defiance disorder and antisocial personality disorder. Differentiating between the disorders requires a preview of the intensity of the disorder. There are many ways to treat CD. The traditional approach has been psychoanalytically oriented psychotherapy. Group therapy is also widely used. The social learning family intervention treatment has received much support from the research. Counseling issues to look at concerning CD are the association with depression and attention deficit hyperactivity disorder. In conclusion, it seems that an eclectic approach is the best option for the counselor who is treating the conduct disordered child.

Counseling the Conduct Disordered Child

Conduct disorder is a difficult term to describe. Although is has a specific definition in the DSM-III-R, it is still referred to in many different ways. For example, oppositional defiant disorder (ODD), which is similar to conduct disorder. It has been called a "mild variant or precursor of conduct disorder" (Abikoff & Klein, 1992, p.881). Another example, would be extreme forms of CD are classified as either antisocial personality disorder or unattachment disorder. Both of which present serious problems in later life for everyone involved. One could conclude then, that based on the level of intensity, conduct disorder could be classified as something else.

Counseling these individuals is made much more difficult by the presence of other disorders. Few cases of pure conduct-disordered children have been identified. Research has shown that "pure conduct disorders are not readily identified" (Abikoff & Klein, 1992, p.882). This could be due to lack of an accurate diagnostic tool or that many CD children are classified as something else. CD is often associated with depression and attention deficit hyperactivity disorder (ADHD). In treating them, the counselor must take a dual approach. The counselor must understand both of the disorders involved and how they interact together. This paper provides an analysis of conduct disorder and some of its various treatments, which

will enable the reader to better understand what CD is, the factors affect it, and how to best handle it.

Conduct disorder seems to be primarily a child disorder, because that is where a substantial amount of research is focused. It is characterized by maternal rejection, poor parental supervision, and paternal alcohol abuse in the home setting. It is also characterized by aggression and impulsivity. Conduct disordered children lack certain social skills. These skills affect the social processes of these children, making them more aggressive toward their peers. They display defiance and hostility to adults, inattention to detail and family discord and disorganization. CD also involves repeated lying, stealing, use of obscene language, and the association with kids who are always in trouble. They also could exhibit non-compliance, destructiveness, verbal as well as physical aggression, and fire setting. These are some of the ways conduct disorders manifest themselves. Most children don't show all the characteristics, but exhibit many.

There are many factors that affect the development of conduct disorder. Parental impact has the strongest effect. "Parental psychopathology, high rates of APD, substance abuse and maternal depression have consistently been found in the parents of boys referred for conduct problems" (Frick, Lahey, Loeber, Stouthamer-Loeber, Christ & Hanson, 1992, p. 49). Research has shown that "maternal depressive symptomatology

interacted significantly with the behavior of conduct-disordered children" (Dumas & Gibson, 1990, p. 879). "Two of the strongest correlates to severe conduct problems in children were poor parental supervision and lack of parental involvement in their child's activities" (Frick et al, 1992, p.49). Latch-key or single parent homes are especially at risk for CD children, because of the lack of supervision. The form of discipline and punishment is also related to the development of conduct disorder. "Harsh or abusive forms of discipline, and inconsistent discipline has been linked to severe child conduct problems" (Frick et al, 1992, p. 49). "Parents of CD children typically use aversive, yet ineffective discipline" (Dadds, Sanders, Morrison, & Rebgetz, 1992, p. 505).

Another factor is the negative family interaction. Dadds et al, (1992) stated there were "high rates of aggression in interactions with their children" (p.505) in families with CD children. It seems CD children learn their aggressive coping strategies within the family structure. This is in accordance with the literature, which "indicates that children with CD problems reciprocate family aggression with high levels of aggression" (Dadds et al, 1992, p. 506). This aggression occurs both in the home and outside it. When these children go to school they show aggression in the classroom either against their peers or their teachers. The family is the most effective socializing agent, even though some of the skills learned are

negative. "Conduct-disordered children are clearly part of family system marked by coercion, aggression, and anger" (Dadds et al, 1992, p.512). This is one of the reasons for treating the family and the parents. The child learns how to cope with problems by watching his/her parents cope. In the family "if conflict is present the result is often frustration, anger and acting out" (Magid & McKelvey, 1987, p.231). To change how the child copes with conflict and anger, the counselor must also help the parent to change their coping techniques. That could be the reason family therapy is fairly successful in treating conduct-disordered children. There are many other factors that affect CD, but in the case of a child, the family is usually the most important factor.

One other factor that affects the development of conduct disorders is the child's social status among his/her peers. "Socially rejected children are described by peers and teachers as being significantly less prosocial than most other children" (Cole & Carpentieri, 1990, p. 749). These children also show more task-inappropriate behavior, more aggression toward their peers, more arguing, fewer prosocial overtures, less appropriate play and engage in less social conversation than their peers. A child who doesn't get along with his or her peers is at risk for more problems down the line. "The association between conduct disorder and peer rejection has led to the use of rejected social status as a screening

criterion and to the construction of social skills' interventions for the treatment of conduct disorder" (Cole & Carpentieri, 1990, p. 755). It seems that if a counselor sees a client who has trouble making friends and feels rejected, they should take that as a warning sign of conduct disorder.

There are many treatments that can be used for a child with conduct disorder. The traditional approach to behavioral problems has been named psychoanalytically oriented psychotherapy. The goal of this therapy is the "relief of symptoms that precipitated the child's having been brought to the therapist or clinic" (Erickson, 1987, p. 113). The therapist focuses on the child's feelings and defenses. They are usually seen once or twice a week for as long as a year or more. Treatment of the child is usually accompanied by treatment of one or both parents once a week.

Another type of therapy used with children is group therapy. The group should "consist of children with various types of problems rather than children with the same type of problem" (Erickson, 1987, p. 115). This therapy focuses on reducing symptomology and improving interpersonal relations. Two advantages of this therapy are it is more economical and it is good for problems related to social functioning. There are three basic types of group therapy for children. They are activity group therapy, activity-interview psychotherapy and play group therapy.

Activity group therapy uses materials for arts and crafts to provide a setting for free acting out. There are two criteria for using this therapy. First, the child must have demonstrated a capacity to relate to others. For example, in the child's past there must have been at least one positive relationship. The second criterion is "the capacity to change attitudes and conduct through corrective experiences" (Erickson, 1987, p. 116). Conduct disorders are considered optimal cases for the activity group therapy. They attend sessions once a week for two hours. Usually termination of therapy occurs after two years. The therapist must be totally accepting of the children, relatively passive and gives no attention to the children's hostility and aggression. The therapist's main job is to act "as a model of self-control for the children" (Erickson, 1987, p. 116).

Activity-interview group psychotherapy combines activity group and individual psychotherapy. The therapist encourages the child to be free to act as they choose and to share their problems with the therapist and each other. The focus is "to provide the children with insight into the reasons for their behavior and help them develop more appropriate social responses" (Erickson, 1987, p. 116).

The final form of children's group therapy is play group therapy. It is used for children ages four to six. The therapist uses play materials that symbolize psychological conflicts.

An example would be using dolls to represent the child and the adults. The therapist then interprets his/her behavior.

Research on group therapy has been mixed. "One-third of studies reported positive results, one-third showed mixed outcomes, and the remaining one-third showed no improvement" (Erickson, 1987, p. 116) in children that participated in group therapy. While not being substantial, one-third is better than no kids being helped.

The next therapy that will be discussed is the social learning family intervention. In determining whether or not intervention is appropriate, the following criteria should be applied. The first criterion is to identify the underlying reasons for the behavior and to determine "whether it represents a normative process, a psychopathology, or misguided attempts to meet psychosocial needs" (Carlson & Lewis, 1988, p.16). After identifying the assessment, the counselor could then decide what type of intervention is necessary. The second criterion is identifying the many needs a particular behavior may serve. The third criterion is that intervention must be focused on specific behaviors and groups. An example of this is whether the intervention is to be primary, secondary, or tertiary. The final criterion is the intervention must be matched to the development needs of the client.

The social learning family intervention has had much support in current research. A researcher has "identified structured family intervention based on behavioral social learning principles as the most promising treatment tested to date" (Miller & Prinz, 1990, p. 291).

"The basic premise behind SLFI, is that conduct disorder is acquired and maintained primarily through social learning processes in the family" (Miller & Prinz, 1990, p. 291). This type of intervention focuses on altering the family social environment with the parents as the main agents of this change. The therapist goes into the family and conducts sessions for both the child and the parents. Then sessions are carried out with each the child and the parents individually. Parents are taught various skills such as how to track their children's behavior and monitor their whereabouts, and how to discipline. "In general, these modifications were reported to be successful in reducing covert and overt antisocial behaviors" (Miller & Prinz, 1990, p. 293).

This therapy also focuses on teaching the parents better supervision skills. It has been shown that "children who live in high-delinquency neighborhoods are at considerable risk, but children who live in the same type of neighborhood and have parents whose monitoring skills are meager or disrupted are most at risk" (Patterson, Reid, & Dishion, 1992, p. 64). If

parents can learn how to keep track of their children, the child's risk for CD is lowered.

One recent addition to the basic SLFI treatment, is the child-based approach. This includes a development of cognitive skills training programs for reducing social cognitive processing biases and deficiencies. The focus is on changing how the youth thinks and approaches a social situation. The child learns self-control strategies, which help them to control their aggressive tendencies towards their peers and others.

Another element to consider when working with conduct disorder youth is their related academic problems. "A significant proportion of children referred for conduct disorder evidence severe reading deficits" (Miller & Prinz, 1990, p. 298). Based on this fact, it would follow that if the counselor could refer the child to tutoring and other related services it "may have important secondary benefits on social behaviors at least in classroom settings" (Miller & Prinz, 1990, p. 298). Using this dual approach might substantially improve the chances of a therapy working, because it would address each of the different needs of a CD child. Used together with the child based approach and the SLFI, this treatment seems to have the most success with conduct-disordered children.

Another problem encountered with many conduct disorders is attention deficit hyperactivity disorder (ADHD). A "significant proportion of conduct-disordered children qualifies for a co-diagnosis of ADHD" (Abikoff & Klein, 1992, p. 881). This presents a "double whammy" type of situation. The counselor must decide whether to treat them separately or together. Some treatments have been reputed to work with both disorders, but some have not. If the counselor decides to treat them together, then they might go with Ritalin to control the ADHD and behavior modification to treat them both. Research has shown, though that behavior modification has a small chance of being effective with a conduct disordered child. This could be due to the fact that, although behavior modification could change the child's behavior, they still go home to be socialized in a negative way. When a child receives conflicting messages, they usually go with what their parents tell them.

There has been limited research and conflicting results on the use of psychostimulant treatments (e.g., Ritalin) in the treatment of conduct disorder. They have been found to help initially, but not in the long run. This could be attributed to the fact that most conduct-disorders are cormorbid for ADHD, and Ritalin is used in controlling the symptoms for ADHD.

Treatments that don't use drugs are varied. The most common is behavioral treatment. It often takes the form of

parent management training. "The rationale for this approach is linked to the notion that inappropriate parent-child interactions, particularly coercive interchanges, are instrumental in the development of deviant behaviors" (p. 886). It is aimed at teaching parents skills to reduce problematic child behavior and to increase prosocial behaviors. Parents are trained by therapists in ways to cope with their children and make them act the way they want them to without coercing them. The research on parent training has also been mixed. "Improvements in parent ratings of overt child behaviors such as fighting, tantrum, and oppositional behaviors and in parent attitudes toward their child have frequently been obtained with parent management-training" (p. 886). The research also found a proportion of the cases maintains their improvements after treatment. The conclusion is that the parent skills training works in some cases, but not others.

Two other types of behavior training are social skills training and community based programs. Research has shown that the social skill training is effective, but cannot be generalized outside the setting in which it was tested. Community based programs are primarily used with adolescents and their effectiveness is usually not evident after treatment.

Conduct disorder children tend to be very aggressive in their behavior. They are aggressive because of "deficiencies in

their social problem solving and processing skills" (p. 886). In social situations, they have a tendency to "misperceive neutral social cues as having aggressive valence" (p. 886). These misinterpreted social cues combined with an aggressive coping style learned at home, leads to aggressive behavior. A type of treatment called cognitive-behavioral treatment focuses on the child's social-cognitive deficits. Research has shown that "social cognitive training improved the social behavior of elementary school-aged pure conduct disorders" (p. 886). CBT takes the form of self-instructional training, reinforced self-evaluation, self-monitoring, self-reinforcement, and anger control training. CBT "benefits were not maintained following treatment termination" (p. 887).

Another factor that complicates the treatment of conduct disorders is the "common observation that childhood depression often coexists with conduct problems" (Dadds et al, 1992, p. 505). Much research has been done on the cormorbidity of childhood depression and conduct disorder. It has been shown that "pure" conduct disorders also scored high on the depressive symptomology scales. For example, in one study both CD and children with depression showed "lower levels of effective verbal problem solving and higher levels of aversive verbal content during problem-solving discussions" (Sanders, Dadds, Johnston & Cash, 1992, p. 502). Another study revealed that "the overlap between the underlying dimensions

of depression and conduct disorder persisted even when the confounding effects of shared method variance were controlled" (Cole & Carpentieri, 1990, p. 754). For a child with both depressive symptomology and conduct disorder, the research supports approaches that involve problem-solving and communication skills training. The cognitive behavioral treatment could be used. These types of procedures have been shown to be effective for both disorders. The treatments discussed earlier in the paper could also be used.

Residential Placement

One last issue to cover is the issue of residential placement. Residential placement is usually not an issue for a young child, but for an older child if the parents feel they cannot control them, an institution might be a viable alternative. The disadvantages for a residential placement facility are the cost, the trauma to the child as a result of the separation from the parents, the label of "mentally ill or emotionally disturbed" (Smollar & Condelli, 1990, p. 4), negative effects on the self-esteem and behavior patterns. "Labeling can result in increased dependency behavior in a child and lack of motivation to change, making treatment efforts unduly difficult" (Smollar & Condelli, 1990, p.4). When a child is removed from the home it often carries "the connotation of family failure and at the same time absolves the parents of any responsibility for the youth" (Smollar &

Condelli, 1990, p. 4). This results in deterioration of the family functioning. There are three types of residential placement: group homes, short-term psychiatric hospitals, and public or private mental institutions.

Group homes provide treatment for youths with less severe disorders, who do not require intensive therapy. Conduct disorders would qualify for the group home. "Many of the youths placed in group homes are status offenders or youth who have been diagnosed as emotionally disturbed or socially maladjusted rather than mentally ill" (Smollar & Condelli, 1990, p.5). Little research has been done on the success of group homes in treating the patients.

Both psychiatric hospitals and mental institutions are designed for more intensive therapy, than a conduct disorder usually requires.

Conclusion

After looking through all the treatments, it seems there isn't one treatment that is used more frequently than any of the others. There isn't any one therapy that has a high success rate either. "Depending on the skills of the therapist and the problems at hand, some of these treatments work better than others" (Magid & Mckelvey, 1987, p. 196). There are many factors that affect the success of treatment. They include socioeconomic status, maternal social support, maternal psychopathology and stress, and marital discord. The intensity

and pervasiveness of the disorder must be looked at. One major factor is the presence of other disorders such as ADHD and depression. The counselor must look at all these factors in deciding which treatment to implement. The counselor isn't the only one involved in treatment usually. "Childhood conduct disorder is best viewed as a multifaceted problem across peer, school, and community settings" (Miller & Prinz, 1990, p.299). In counseling these individuals, interaction, cooperation and communication is needed among many professionals in the child's life. It seems that an eclectic approach is the best way to deal with a conduct disordered child. This could be because CD also manifests many other problems such as academic problems and other disorders. Instead of having one approach, the counselor should be prepared to use many techniques and attempt to control the factors that affect the success rate of treatment.

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